GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Regulation
& Licensing Administration

HEALTH CERTIFICATE FOR STAFF

NAME: _____ **SEX:** MALE FEMALE

DATE OF BIRTH: _____ **TELEPHONE NO**: _____

ADDRESS: _____
STREET **CITY** **STATE** **ZIP CODE**

TYPE OF PROFESSIONAL LICENSE: _____

I have examined the above-named person and certify that he/she is:

1. Free from disease in communicable form.
2. The following tests have been done:

Tuberculin test (check one): Tine PPD

Date: _____ Result: _____

Chest X-Ray, Date: _____ Result: _____

Remarks:

_____

_____

_____

_____ _____
SIGNATURE OF HEALTH CARE PRACTITIONER **DATE OF EXAMINATION**

_____ (_____)_____
ADDRESS OF HEALTH CARE PRACTITIONER **TELEPHONE NO**